LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU, QUALITY ASSURANCE DIVISION

FY 15/16 STATE CHART REVIEW PREPARATION INSTRUCTIONS

These instructions are designed to assist providers in preparing their clinical record(s) for the Department of Health Care Services (DHCS) State System Review, Outpatient Chart Review. The Department needs your cooperation in preparing for this review in accord with these instructions to ensure the clinical record(s) are "reviewer friendly," and that relevant information is as easy as possible for the review team to find.

Note: If State reviewers are unable to find information that is critical to the support of a paid claim at the time of the review, the service will be disallowed. Providers will not be allowed to submit additional information supporting claims once the review has begun. The Department will not be able to appeal disallowances that were based on information not found in the record at the time of the review.

OVERVIEW

- State DHCS will conduct the review
- The review will be guided by MHSUDS Information Notice No. 15-042 which includes these related materials:
  - Section K of the Review Protocol – used to review all outpatient claims
  - Reasons for Recoupment
- The review will be conducted at DMH Headquarters Annex, 695 S. Vermont, 15th Fl. Glass Conference Room
- Audit Sample Information
  - DHCS will randomly select 80 clients (distributed between adult and child) from the entire Los Angeles service delivery system
  - All claims regardless of service provider (direct or contract), within the review period, will be reviewed for each client
- Only the Federal Financial Participation (FFP) will be recouped.

NOTIFICATION

On February 11th and 12th, the Quality Assurance Division will notify providers selected for the Chart Review. Providers will be notified by phone and/or email. Upon notification, the QA Division will provide a Chart Tracking Log. The Chart Tracking Log contains the list of client names for which the provider must produce records for the chart review. In addition to the Chart Tracking Log, the provider will be given a list of services with rendering providers/practitioners that were claimed during the review period.

ELECTRONIC HEALTH RECORDS

This will be a hard-copy, paper record review. Any provider using an Electronic Health Record (EHR) must provide a hard-copy, paper record for the review. EHRs will not be reviewed during the Chart Review. All documentation and supporting documentation related to services provided to a client during the review period must be printed and provided in hard-copy format. This minimally must include the documents identified in the "Preparation of Records" section of this document.

Any documents where the signature was obtained electronically via electronic signature must have a notation on the printed documentation that the document was signed electronically. All EHRs using electronic signatures must have an electronic signature agreement on file with LACDMH (see the Electronic Signature Agreement Memo posted on the Chart Review webpage for additional information). Any questions related to the printing of an EHR for this review should be directed to Jennifer Hallman at jhallman@dmh.lacounty.gov.

Note: For Directly-Operated providers using IBHIS, the Quality Assurance Division will be printing and flagging the clinical records. Directly-Operated providers using IBHIS do not need to submit any records.

PREPARATION OF RECORDS

Flag the following information in each clinical record so the review team may easily find the required information. With the exception of Demographics and Cultural Considerations/Special service Needs, the absence of any of this information will result in a review finding and/or disallowance.

- **Demographics** (**GREEN TAG**): The Client Face Sheet or other document listing the client's primary language, ethnicity, race, date of birth and gender must be flagged with a **green tag**.
- **Assessment(s)/Medical Necessity** (YELLOW TAG): The following three items must be flagged with a yellow tag:
  - **Assessment(s)** – Any assessments that cover the review period including Initial/Full Assessments, Re-Assessments, Annual Assessment Updates/Continuous Client, and Assessment Addendums as well as the assessment that proceeds the review period (if applicable) should be flagged. *For example, if a Full/Initial Assessment was done and then an Annual Assessment Update was done prior to the review period, both documents would be flagged. If only a Full/Initial Assessment was completed, only the Full/Initial Assessment would be flagged.*
  - **Diagnosis** – The client's diagnosis covering the review period should be flagged. The diagnosis may be present on an assessment form or diagnosis form. If the client has received treatment services, the primary diagnosis should be a Medi-Cal Included Diagnosis.

  - **Life Functioning Impairment/Risk of Deterioration** – Documentation of the impairments in life functioning and/or risk of deterioration should be flagged. It may be present on an assessment form, Community Functioning Evaluation or other form.
- **Client Treatment Plan(s)** (**ORANGE TAG**) – The following three items must be flagged with an **orange tag**:
  - **Client Treatment Plan(s)** – The Client Treatment Plan that covers the review period as well as the Client Treatment Plan preceding the review period, if applicable.
  - **Client Participation** – The client or legal representative signature should be flagged. If it is not present, justification for the lack of client signature or demonstration of participation and agreement in the treatment planning process should be flagged.
  - **Signature of AMHD** - Services must be delivered under the direction of an Authorized Mental Health Discipline (AMHD): licensed MD/DO, certified NP, registered CNS, registered RN, licensed or waivered PhD/PsyD, LCSW or registered/waivered ASW, licensed MFT or registered/waivered MFT, and licensed professional clinical counselor (LPCC) or registered/waivered PCC.
- **Progress Notes** (**BLUE TAG**) – The first and last progress note of the review period should be flagged with a **blue tag**. If a separate section is kept for medication notes, then the first and last progress note of the review period within the medication notes section should also be flagged with a **blue tag**. For Day Treatment Intensive and Day Rehabilitation programs, the flagging should include daily notes and/or weekly summaries.
- **Consent for Medications** (**RED TAG**) – Any consent for medications that covers the review period for client's prescribed medications should be flagged with a **red tag** (if applicable).
- **Cultural Considerations/Special Service Needs** (**PURPLE TAG**) – Any cultural, linguistic, hearing or visual issues that could limit or prevent access to services should be flagged with a purple tag. In addition, any documentation demonstrating accommodations were provided to allow for successful access to services and resources should be flagged with a **purple tag**.

ANCILLARY FOLDERS

Each clinical record that is submitted must be accompanied by an Ancillary Folder labeled with the client name and ID. The Ancillary Folder should include the following items:

- **Contact Information:** Each provider must identify at least one contact person should questions arise while their records are being reviewed. This person should be one who is knowledgeable regarding the provider's records and documentation practices and should be available during the review (February 22nd through March 4th).
- **Chart Order:** Provide a document describing the order of documents in the clinical record provided. This assists the review team to find documents during the review and orient them to the clinical record.
- **Medicare/OHC EOB:** If the client has Medicare or other health coverage, provide any applicable explanation of benefits (EOB) from the review period.

- **Voided Claims:** If any claims from the review period were voided, provide evidence of the voided claim.
- **Staff Information Sheet:** Provide a list of all rendering providers/practitioners who provided services/signed clinical documents during the review period. If you have paper clinical records and do not use electronic signatures, have each rendering provider/practitioner sign the staff information sheet. This assists the review team in verifying signatures during the review.
- **Staff Category Verification:** For each rendering provider/practitioner on the staff information sheet, provide the license, registration, waiver or diploma/resume. This assists in verifying the staff credentials during the review.
- **DTI/DR Program Documentation:** Day Treatment Intensive and Day Rehabilitation providers must provide their detailed weekly schedule of activities for the review period as well as the detailed written description of each service component provided (community meetings, process groups, skill building groups, adjunctive therapies, and, if applicable, psychotherapy)

SUBMISSION, RETURN, AND SECURITY OF RECORDS

In accord with Department Policy, all records must be transported to the Quality Assurance (QA) Division at the DMH Headquarters Annex (695 S. Vermont Ave, 15th floor) in secured containers. Instructions are provided on the Chart Review webpage indicating to whom, where, and when clinical records and ancillary folders must be submitted.

The QA staff will sign the clinical records in and give the provider a copy of the Chart Tracking Log as a receipt. It is expected that clinical records will be delivered by a manager, supervisor or QA coordinator. Provider clerical/administrative staff will not be allowed to drop off records. Staff dropping records should be prepared to remain at the office while the records are reviewed.

The QA staff will review records when they are delivered to ensure that records have been properly flagged and all information required for the Ancillary Folder has been included. In addition, QA staff will ask if there are any upcoming appointments for the client for which the clinical record will be needed. To minimize impact on service delivery, if a record will be needed by the provider prior to the end of the review on March 4th, please provide QA staff the specific date and time the record is needed. Unless a client is coming in for an appointment the morning of the first day of the review, we anticipate being able to make records available for the provider to pick-up if they are needed during that week. We also recommend that providers copy relevant progress notes and other necessary information on those client records that have appointments during the review period. QA staff will be responsible for securing records upon their delivery and during the course of the review.

QA staff will return records directly to any provider who attends the Exit Conference. All other records will be returned to providers upon pick-up from the QA Division (where and when clinical records may be picked up can be found on the chart review webpage). Staff picking up records will be required to sign for receipt of the records.